fold. He was afraid upon finding these glands that a mistake might have been made in the diagnosis, but subsequent histological study proved that they were not malignant.

DR. JOHN H. GIBSON said that until he witnessed Kocher's operations upon goitre he thought his own failure to relieve pain with infiltration anæsthesia in these cases was due to a faulty technique, but that now he thinks this was not the case. Kocher's local anæsthesia consists entirely in an anæsthesia of the skin; the rest of the operation is carried on practically without an anæsthetic, and can only be borne by the Swiss peasants. Kocher himself admits that in the more highly cultivated and organized patients he is obliged to use a general anæsthetic.

MULTIPLE FRACTURES INVOLVING THE UPPER EXTREMITY.

DR. ASTLEY P. C. ASHHURST exhibited four patients who had sustained multiple fractures, and discussed the subject in a paper, for which see page 263.

DR. JOHN H. JOPSON cited a case of multiple fractures treated in the Presbyterian Hospital as an illustration of the shock that results from such injuries. An Italian was thrown from a wagon and sustained a fracture of the pelvis, the shaft of the humerus, one or both clavicles, and a Pott's fracture. The fracture of the humerus was complicated by paralysis of the musculo-spiral nerve. Shock was great and prolonged, but the patient made a good recovery. There is now under his care in the Children's Hospital a child referred because of supposed rachitic deformities, who was found to have a fracture of the right thigh, both bones of the right leg, and both bones of the left leg, evidently of rachitic origin, and with no history of traumatism. All surgeons are familiar with multiple fractures due to carcinoma. In Dr. Jopson's experience, the double Colles's fracture is the commonest example of multiple fracture encountered.

DR. GEORGE G. ROSS mentioned two cases of multiple fractures. One was in a woman of 65, weighing 250 pounds, and included a fracture of the middle of the shaft of the right humerus, a Colles's fracture of the right side and a Colles's fracture of the left side. The patient recovered. The second case was a multiple fracture of the upper extremity, including a fracture of the middle of the humerus and what corresponded to a Colles's fracture on the same side, though there had previously

been a fracture in that location. The man was violently drunk and no history could be obtained. There was great trouble in controlling the upper fracture.

DR. WILLIAM J. TAYLOR cited the case of a woman who had a fracture of one patella wired by another surgeon and afterward came to him with a fracture of the other patella. He wired that one, but soon after recovery the woman got drunk and refractured it, the bone breaking at the line of union and also in three other places. It was again wired, but the woman again got drunk and fractured the patella a third time.

DR. RICHARD H. HARTE said, regarding the question of repair in these cases, he has noticed in a number of instances that nature appears capable of carrying on only a certain amount of repair; that is, multiple fractures do not unite so quickly as do single fractures. When three bones are broken some one of them will remain practically without union until the others have united, and will then unite in the ordinary manner. It might be said that something was between the fragments preventing union, but that is not the case; the tissues simply lie dormant while the others are healing, and then union promptly occurs. He is surprised that such a close observer as Dupuytren should state that multiple fractures unite as readily as does a single fracture.

DR. ASHHURST, in closing, said that Dr. Harte had apparently misunderstood his reference to Dupuytren's statements. The latter had referred to the union of multiple fractures with less inflammatory reaction in each than is ordinarily the case where only one fracture is present; and by inflammatory reaction Dupuytren no doubt understood the formation of excessive callus, as well as profuse suppuration, the latter of course being a much more prominent feature of compound fractures in Dupuytren's time than it has become since the general adoption of antiseptics. In Dr. Ashhurst's fifth case union did not begin in the forearm until that of the humerus was quite firm. Dr. Ashhurst thought the treatment adopted by Dr. Neilson in the first case reported was interesting in connection with the attempts now being made to secure union in ununited fractures of the neck of the femur without screw or wire fixation, by freshening the bone fragments and then dressing the thigh in a plaster cast in the position of extreme abduction. In the humerus thus treated (Case 1) firm union had occurred without difficulty, and in at least one case of

fractured femur of which Dr. Ashhurst was cognizant, a patient under Dr. Davis's care, the same result was obtained.

RHINOPHYMA.

Dr. John H. Gibbon exhibited a case of rhinophyma upon which he had operated. The patient was 57 years of age. The condition had gradually developed in about 4 or 5 years. The lateral aspects of the lower portion of the nose were covered with large pedunculated masses of hypertrophied tissue. The whole lower half of the nose was involved, although over the central portion there were none of the pedunculated tumors.

Dr. Gibbon removed all of the hypertrophied tissue with a scalpel, shaving off the outer layers of the skin over the whole involved area. The bleeding was quite profuse and there was an escape of a large amount of sebaceous material from the divided ducts and glands. The bleeding was controlled simply by pressure. The patient left the hospital without a dressing at the end of a week, and in two weeks the entire area was covered by new skin.

GALL-STONES WITH SUBACUTE PANCREATITIS.

Dr. Edward B. Hodge reported the case of a man, aged 27 years, who was admitted to Dr. J. H. Musser's service at the Presbyterian Hospital October 30, 1906. Nausea, vomiting, sharp epigastric pain of 12 hours' duration. Subject to similar attacks for some years. Never had typhoid fever. Examination showed moderate distension, slight rigidity of upper right rectus, distinct tenderness in the epigastrium, most marked over gall-bladder. Pain extends to the left side, but not to the back or shoulder. Later, gall-bladder could be felt and slight transient jaundice developed. Highest temperature, 101.4°; pulse, 100; respiration, 20.

Two weeks later, after attack had subsided, operation was performed in Dr. DeForest Willard's service. Right rectus incision. Very extensive fat necrosis in omentum, mesentery, and subperitoneal fat. Collection of purulent material between gall-bladder, liver, and pylorus, amounting to about 2 oz. Gall-bladder not distended, and containing one large and a dozen small stones. Dense adhesions about gall-bladder, ducts, pancreas, and pylorus.